	DEPARTMENT OF PUBLIC SAFETY CORRECTIONS ADMINISTRATION POLICY AND PROCEDURES		EFFECTIVE DATE: 1/7/09	POLICY NO.: COR.10.1B.02
			SUPERSEDES (Policy No. & Date): NEW	
	SUBJECT: PATIENT SAFETY			Page 1 of 3

1.0 PURPOSE

The purpose of this policy is to reduce risk and harm to patients through a safety system focused on strategies that improve clinical practice.

2.0 REFERENCES AND DEFINITIONS

.1 References

- a. Hawaii Revised Statutes, Section 26-14.6, Department of Public Safety; and Section 353C-2, Director of Public Safety, Powers and Duties.
- b. National Commission on Correctional Health Care, Standards for Health Services in Prisons and Jails (2008).

.2 Definitions

- a. Adverse Clinical Event: injury or death caused by medical management rather than by the patient's underlying disease or condition.
- b. Error Reporting System: includes policies and procedures that outline how health care staff voluntarily identify and report all clinical errors, whether the error occurs by omission or commission.
- c. Near Miss Clinical Event: an error in clinical activity without consequential adverse patient outcomes.
- d. Patient Safety Systems: practices and/or interventions designed to prevent adverse or near miss-clinical events.

3.0 POLICY

- .1 The Clinical Services Branch Administrator in conjunction with the facility Clinical Section Administrators proactively implements patient safety systems to prevent adverse and near miss clinical events.
- .2 The Clinical Services Branch Administrator in conjunction with the facility Clinical Section Administrators implements an error reporting system for health staff to voluntarily report, in a non-punitive environment, errors that affect patient safety.

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4.0 **PROCEDURES**

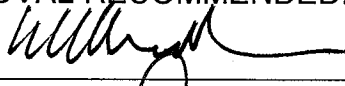
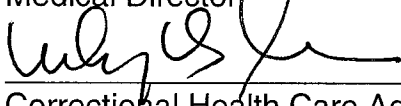
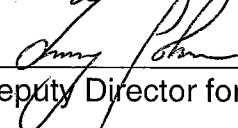
- .1 All newly hired nursing staff undergo a thorough orientation including the successful passing of a medication administration skills test and a complete review of all nursing procedures, departmental policies and procedures per the orientation policy.
- .2 All nursing staff undergoes an initial and then yearly review of their Core Competency skills necessary to perform within a correctional setting.
- .3 All nursing staff receive education on the medication error reporting procedure.
- .4 All errors and near misses are confidentially reported to the responsible health authority who evaluates it for trends and potential process improvement. RHA shall determine if additional training is needed for the nurse or possibly the entire staff to improve clinical skills. All reports eventually are reviewed by the Clinical Services Branch Administrator who evaluates for system wide trends and the need for retraining.
- .5 All errors and near misses are reported in a non-punitive supportive environment. Data is used to evaluate for trends, review current practice patterns and ultimately improve patient practice through incorporation into the facility CQI process.
- .6 A component of the patient safety program is the implementation of a medical record archival system which allows for easy quick retrieval of old medical records in an electronic format at any facility at any time of the day via the internet.
- .7 All patients now wear either a picture or picture wrist ID which is used for patient identification during medication pass to decrease medication errors do to inmates attempted to identify themselves as some one else

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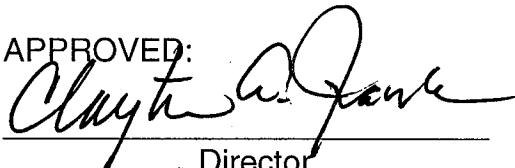
5.0 SCOPE

This policy and procedures applies to all correctional facilities and their assigned personnel.

APPROVAL RECOMMENDED:

	1/2/09
Medical Director	Date
	1/2/09
Correctional Health Care Administrator	Date
	1/2/09
Deputy Director for Corrections	Date

APPROVED:


Director
1/7/09
Date